FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027052

Facility Name: LAKE PARK CENTER

Address: 919 WASHINGTON PARK (Number) WAUKEGAN (City) 60085 (Zip Code)

County: LAKE

Telephone Number: (847) 623-9100 **Fax #** (847) 623-9100

IDPA ID Number: 36-3109638

Date of Initial License for Current Owners: 02/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,860	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	67,894	421	5,895	74,210	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,894	421	5,895	74,210	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 96.55%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started _____

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	251,061	13,406	8,667	273,134		273,134	0	273,134			1
2	Food Purchase		197,315		197,315		197,315	(518)	196,797			2
3	Housekeeping	202,165	32,679	0	234,844		234,844	0	234,844			3
4	Laundry	85,649	13,635	3,943	103,227		103,227	0	103,227			4
5	Heat and Other Utilities			134,783	134,783		134,783	132	134,915			5
6	Maintenance	105,871	12,806	27,971	146,648		146,648	8,207	154,855			6
7	Other (specify):*			12,509	12,509		12,509	0	12,509			7
8	**TOTAL General Services**	644,746	269,841	187,873	1,102,460		1,102,460	7,821	1,110,281			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400	0	4,400			9
10	Nursing and Medical Records	1,726,811	142,813	25,443	1,895,067		1,895,067	1,666	1,896,733			10
10a	Therapy	76,109		5,426	81,535		81,535	0	81,535			10a
11	Activities	99,174	3,337	4,025	106,536		106,536	0	106,536			11
12	Social Services	0		4,538	4,538		4,538	0	4,538			12
13	Nurse Aide Training			400	400		400	0	400			13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,902,094	146,150	44,232	2,092,476		2,092,476	1,666	2,094,142			16
	C. General Administration											
17	Administrative	86,541		680,000	766,541		766,541	(657,751)	108,790			17
18	Directors Fees			0				0				18
19	Professional Services			27,522	27,522		27,522	21,416	48,938			19
20	Dues, Fees, Subscriptions & Promotions			31,722	31,722		31,722	(5,283)	26,439			20
21	Clerical & General Office Expense	60,977	11,558	160,295	232,830		232,830	(97,404)	135,426			21
22	Employee Benefits & Payroll Taxes			440,962	440,962		440,962	0	440,962			22
23	Inservice Training & Education			2,605	2,605		2,605	109	2,714			23
24	Travel and Seminar			3,527	3,527		3,527	(3,527)				24
25	Other Admin. Staff Transportation			133,135	133,135		133,135	855	133,990			25
26	Insurance-Prop.Liab.Malpractice			85,894	85,894		85,894	2,035	87,929			26
27	Other (specify):*			50,000	50,000		50,000	(37,410)	12,590			27
28	**TOTAL General Administration**	147,518	11,558	1,615,662	1,774,738		1,774,738	(776,960)	997,778			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,694,358	427,549	1,847,767	4,969,674		4,969,674	(767,473)	4,202,201			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			24,344	24,344		24,344	6,882	31,226			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							2,468	2,468			32
33	Real Estate Taxes			87,360	87,360		87,360	2,503	89,863			33
34	Rent-Facility & Grounds			506,754	506,754		506,754	(15,750)	491,004			34
35	Rent-Equipment & Vehicles			32,330	32,330		32,330	7,055	39,385			35
36	Other (specify):* office rent			15,750	15,750		15,750	0	15,750			36
37	TOTAL Ownership			666,538	666,538		666,538	3,158	669,696			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers							0				39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			115,290	115,290		115,290	0	115,290			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			115,290	115,290		115,290		115,290			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,694,358	427,549	2,629,595	5,751,502	0	5,751,502	(764,315)	4,987,187			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	4,405	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(518)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties	(26)	21		18
19	Entertainment	0	20		19
20	Contributions	(292)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(50,000)	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(4,987)	20		28
29	Other-Attach Schedule DEFE.MAINT XIX-H, TRAVEL	642			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,176)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(713,139)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (713,139)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (764,315)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other

STATE OF ILLINOIS **Page 5A**

Facility Name: LAKE PARK CENTER
ID#: 0027052
Report Period Beginning: 01/01/2008
Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.			Line 1	0
1	**Day Care**	0	0	Line 2	(193)
2	**Other Cars for Outpatients**	0	0	Line 3	0
3	**Governmental Sponsored Special Programs**	0	0	Line 4	0
4	**Non-Patient Meals**	0	2	Line 5	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	Line 6	4,180
6	**Rented Facility Space**	0	34	Line 7	0
7	**Sale of Supplies to Non-Patients**	0	10	Line 8	3,987
8	**Laundry for Non-Patients**	0	4	Line 9	0
9	**Non-Straightline Depreciation**	4,405	30	Line 10	0
10	**Interest and Other Investment Income**	0	32	Line 10a	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	Line 11	0
12	**Non-Working Officer's or Owner's Salary**	0	0	Line 12	0
13	**Sales Tax**	(518)	2	Line 13	0
14	**Non-Care Related Interest**	0	32	Line 14	0
15	**Non-Care Related Owner's Transactions**	0	0	Line 15	0
16	**Personal Expenses (Including Transportation)**	0	25	Line 16	0
17	**Non-Care Related Fees**	(400)	20	Line 17	0
18	**Fines and Penalties**	(26)	21	Line 18	0
19	**Entertainment**	0	20	Line 19	0
20	**Contributions**	(292)	20	Line 20	(5,429)
21	**Owner or Key-Man Insurance**	0	22	Line 21	(292)
22	**Special Legal Fees & Legal Retainers**	0	19	Line 22	0
23	**Malpractice Insurance for Individuals**	0	26	Line 23	0
24	**Bad Debt**	(50,000)	27	Line 24	(3,527)
25	**Fund Raising, Advertising and Promotional**	0	20	Line 25	0
26	**Income & IL Personal Property Replacement T**	0	0	Line 26	0
27	**Nurse Aide Training for Non-Employees**	0	13	Line 27	(50,000)
28	**Yellow Page Advertising**	(4,987)	20	Line 28	(59,233)
29	**Non-Paid Workers**	0	0	Line 29	(55,746)
30	**Donated Goods**	0	0	Line 30	4,405
31	**Amortization Expense**	0	0	Line 31	0
32	Deferred Maint XIX-H	4,169	6	Line 32	0
33	Travel out of State	(3,527)	24	Line 33	0
34				Line 34	0
35				Line 35	0
36				Line 36	0
37				Line 37	4,405
38				Line 38	0
39				Line 39	0
40				Line 40	32
41				Line 41	0
42				Line 42	0
43				Line 43	0
44				Line 44	0
45				Line 45	(51,139)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb LAKE PARK CENTER **# 0027052** **Report Period Beginning: 01/01/2000** **Ending: 12/31/2000**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(518)	0	0	0	0	0	0	0	0	0	0	(518)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	132	0	0	0	0	0	0	0	0	132	5
6	Maintenance	4,169	2,794	1,244	0	0	0	0	0	0	0	0	8,207	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,651	2,794	1,376	0	0	0	0	0	0	0	0	7,821	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,666	0	0	0	0	0	0	0	0	0	1,666	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	1,666	0	0	0	0	0	0	0	0	0	1,666	16
	C. General Administration													
17	Administrative	0	0	0	(657,751)	0	0	0	0	0	0	0	(657,751)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,565	123	728	0	0	0	0	0	0	0	21,416	19
20	Fees, Subscriptions & Promotions	(5,679)	396	0	0	0	0	0	0	0	0	0	(5,283)	20
21	Clerical & General Office Expenses	(26)	(107,673)	82	10,213	0	0	0	0	0	0	0	(97,404)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	109	0	0	0	0	0	0	0	0	0	109	23
24	Travel and Seminar	(3,527)	0	0	0	0	0	0	0	0	0	0	(3,527)	24
25	Other Admin. Staff Transportation	0	277	0	578	0	0	0	0	0	0	0	855	25
26	Insurance-Prop.Liab.Malpractice	0	1,380	118	537	0	0	0	0	0	0	0	2,035	26
27	Other (specify):*	(50,000)	8,489	0	4,101	0	0	0	0	0	0	0	(37,410)	27
28	**TOTAL General Administration**	(59,232)	(76,457)	323	(641,594)	0	0	0	0	0	0	0	(776,960)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,581)	(71,997)	1,699	(641,594)	0	0	0	0	0	0	0	(767,473)	29

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,405	818	1,302	357	0	0	0	0	0	0	0	6,882	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,468	0	0	0	0	0	0	0	0	2,468	32
33	Real Estate Taxes	0	0	2,503	0	0	0	0	0	0	0	0	2,503	33
34	Rent-Facility & Grounds	0	0	(15,750)	0	0	0	0	0	0	0	0	(15,750)	34
35	Rent-Equipment & Vehicles	0	4,448	0	2,607	0	0	0	0	0	0	0	7,055	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,405	5,266	(9,477)	2,964	0	0	0	0	0	0	0	3,158	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,176)	(66,731)	(7,778)	(638,630)	0	0	0	0	0	0	0	(764,315)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe LAKE PARK CENTEI # 0027952 Report Period Beginning 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULA ATTACHED		LIST ATTACHED		EKS MANAGEME	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISE	LINCOLNWOOD	CONSULTANT
				IME REALTY COI	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	21 OUTSIDE CLERICAL SERVI	146,375	EKS MANAGEMENT	6		(146,375)	1	-146375
2	V	8 PAINTING SALARIES				2,794	2,794	2	2794
3	V	10 RN CONSULTANT SALARIES				1,666	1,666	3	1666
4	V	19 PROFESSIONAL FEES				20,565	20,565	4	20565
5	V	20 WANT ADS				396	396	5	396
6	V	21 TOTAL OFFICE				38,702	38,702	6	38702
7	V	22 SEMINAR				109	109	7	109
8	V	25 TRANSPORTATION				277	277	8	277
9	V	26 INSURANCE				1,380	1,380	9	1380
10	V	27 EMPLOYEE BENEFITS				8,489	8,489	10	8489
11	V	28 DEPRECIATION (SL)				818	818	11	818
12	V	25 EQUIPMENT RENTAL				4,448	4,448	12	4448
13	V							13	
14	Total		$ 146,375		$	79,644	$ * (66,731)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	OFFICE RENT	$ 15,750	IME REALTY CORP.		$	$ (15,750)	15	-15750
16	V	5	UTILITIES				132	132	16	132
17	V	6	REPAIR/MAINTENANCE				1,244	1,244	17	1244
18	V	19	PROFESSIONAL FEES				123	123	18	123
19	V	21	OFFICE EXPENCE				82	82	19	82
20	V	26	INSURANCE				118	118	20	118
21	V	30	DEPRECIATION (SL)				1,302	1,302	21	1302
22	V	32	INTEREST				2,468	2,468	22	2468
23	V	33	REAL ESTATE TAX				2,503	2,503	23	2503
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 15,750			$ 7,972	$ * (7,778)	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6B
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V		17	MANAGEMENT FEES	$ 680,000	EMI ENTERPRISES, INC.		$	$ (680,000)	15	-680000
16	V		17	OFFICERS SALARY				22,249	22,249	16	22249
17	V		19	ACCOUNTING FEES				728	728	17	728
18	V		21	TOTAL OFFICE				10,213	10,213	18	10213
19	V		25	TRANSPORTATION				578	578	19	578
20	V		26	INSURANCE				537	537	20	537
21	V		27	EMPLOYEE BENEFITS				4,101	4,101	21	4101
22	V		30	DEPRECIATION				357	357	22	357
23	V		35	AUTO LEASE				2,607	2,607	23	2607
24	V									24	
25	V									25	
26	V									26	
27	V									27	
28	V									28	
29	V									29	
30	V									30	
31	V									31	
32	V									32	
33	V									33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	Total				$ 680,000			$ 41,370	$ * (638,630)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MORRIS ESFORMES	GEN. PARTNER	ADMINISTRATIVE		SEE ATTACHED				$ 22,249	17-8	1
2					SCHEDULE						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,249		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

the name(s)
PORTS.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING SALARIES	PATIENT DAYS	617,052	11	$ 23,229	$ 23,229	74,210	$ 2,794	1
2	10	RN CONSULTANT SALARI	PATIENT DAYS	617,052	11	13,856	13,856	74,210	1,666	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	617,052	11	170,994	131,341	74,210	20,565	3
4	20	WANT ADS	PATIENT DAYS	617,052	11	3,290		74,210	396	4
5	21	TOTAL OFFICE	PATIENT DAYS	617,052	11	321,801	269,147	74,210	38,702	5
6	23	SEMINAR	PATIENT DAYS	617,052	11	905		74,210	109	6
7	25	TRANSPORTATION	PATIENT DAYS	617,052	11	2,302		74,210	277	7
8	26	INSURANCE	PATIENT DAYS	617,052	11	11,476		74,210	1,380	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	70,589		74,210	8,489	9
10	30	DEPRECIATION (SL)	PATIENT DAYS	617,052	11	6,797		74,210	818	10
11	35	EQUIPMENT RENTAL	PATIENT DAYS	617,052	11	36,988		74,210	4,448	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 662,227	$ 437,573		$ 79,644	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: IME REALTY CORP
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	201,349	11	$ 1,685	$	15,750	$ 132	1
2	6	REPAIR/MAINTENANCE	INCOME	201,349	11	15,902		15,750	1,244	2
3	19	PROFESSIONAL FEES	INCOME	201,349	11	1,575		15,750	123	3
4	21	OFFICE EXPENCE	INCOME	201,349	11	1,047		15,750	82	4
5	26	INSURANCE	INCOME	201,349	11	1,504		15,750	118	5
6	30	DEPRECIATION (SL)	INCOME	201,349	11	16,647		15,750	1,302	6
7	32	INTEREST	INCOME	201,349	11	31,549		15,750	2,468	7
8	33	REAL ESTATE TAX	INCOME	201,349	11	32,000		15,750	2,503	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 101,909	$		$ 7,972	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: EMI ENTERPRISES, INC
Street Address: 3737 W. W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	617,052	11	$ 185,000	$ 185,000	74,210	$ 22,249	1
2	19	ACCOUNTING FEES	PATIENT DAYS	617,052	11	6,053		74,210	728	2
3	21	TOTAL OFFICE	PATIENT DAYS	617,052	11	84,917	64,123	74,210	10,213	3
4	25	TRANSPORTATION	PATIENT DAYS	617,052	11	4,810		74,210	578	4
5	26	INSURANCE	PATIENT DAYS	617,052	11	4,462		74,210	537	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	617,052	11	34,099		74,210	4,101	6
7	30	DEPRECIATION	PATIENT DAYS	617,052	11	2,964		74,210	357	7
8	35	AUTO LEASE	PATIENT DAYS	617,052	11	21,677		74,210	2,607	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 343,982	$ 249,123		$ 41,370	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Numbe LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	88,968	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	88,164	2
3. Under or (over) accrual (line 2 minus line 1).	$	(804)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	88,164	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	87,360	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	81,551	8
	1996	82,838	9
	1997	87,519	10
	1998	88,969	11
	1999	88,164	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Numb LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,175 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 0 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		0		$	1
2					2
3	TOTALS	0		$ 0	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8	IME ALLOCATION					1,067		1,067			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	PAINTING			1986	15,680	197	15	131	(66)	14,300	9
10	ASHALT PAVING			1987	8,180	260	15	545	285	7,175	10
11	AVAC UNITS			1988	45,000	1,429	20	2,250	821	28,313	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		20,145	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		6,148	13
14	PARKING LOTS			1993	19,440	1,296	15	1,296		9,404	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	57	11	409	15
16	NURSES STATION			1993	7,800	200	31.5	248	48	1,774	16
17	ELEVATOR			1994	22,300	572	39	572		3,694	17
18	CUBICLE CURTAINS			1994	843	22	39	22		149	18
19	PARKING LOT LIGHT			1995	8,677	578	15	578		3,179	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		1,365	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		955	21
22	TILE			1996	20,387	522	39	522		2,242	22
23	WEATHER - ROOFTOP			1997	6,408	164	39	164		499	23
24	METALL DOORS & AIR CONDITION			1998	11,993	308	39	308		885	24
25	TWO SHOWERS			1998	2,720	70	39	70		195	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		617	26
27	CABINERRY -ADM., BOOKKEEPING, DON			1998	33,000	846	39	846		1,939	27
28	WATER HEATER			1998	4,639	119	39	119		253	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		181	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		916	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOORS FIRE			1999	18,547	476	39	476		496	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANI			1999	8,640	222	39	222		250	32
33	FIRE DAMPERS			2000	8,070	159	27.5	159		159	33
34	FENCE			2000	6,810	76	15	76		76	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 12,552		$ 13,651	$ 1,099	$ 105,718	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Numbe LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Numbe LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Numbe LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Numbe LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 161,325	$ 12,859	$ 16,165	$ 3,306	5-10	$ 98,259	37
38	Current Year Purchases	0						38
39	Fully Depreciated Assets	162,780					162,780	39
40	IME,EMI,EKS ALLOCATION		1,410	1,410				40
41	TOTALS	$ 324,105	$ 14,269	$ 17,575	$ 3,306		$ 261,039	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 26,821	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 31,226	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 4,405	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 366,757	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WAUKEGAN HEALTH CARE INC.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1967	210		$ 506,754			3
4	Additions							4
5								5
6								6
7	TOTAL		210		$ 506,754 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/01/86
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 506,754
13.	12/31/2002	$ 506,754
14.	12/31/2003	$ 506,754

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipm $ 13,298 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	NURSE, ACTIVITY	1998 CHEVY VAN	$ 550.00	$ 6,600	17
18	NURSING	1998 DODGE VAN	450.00	5,400	18
19	MAINTENANCE	1999 TOYOTA SIENNA	586.00	7,032	19
20					20
21	TOTAL		$ ######	$ 19,032	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		400		400
9	TOTALS	$	$ 400	$	$ 400
10	SUM OF line 9, col. 1 and 2 (e)	$ 400			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

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Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits				N/A			6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 387,774	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	882,535		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	113,547		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	513,875		8
9	Other(specify): Real Estate Escrow Deposit	56,299		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,954,030	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	385,501		15
16	Equipment, at Historical Cost	324,105		16
17	Accumulated Depreciation (book methods)	(390,790)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	100,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 418,816	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,372,846	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 264,942	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,853		30
31	Accrued Taxes Payable (excluding real estate taxes)	38,211		31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,164		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 481,170	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 481,170	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,891,676	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,372,846	$	48

***(See instructions.)**

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Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,777,484	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(18,434)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,759,050	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,214,126	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,081,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 132,626	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,891,676	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,965,396	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,965,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	232	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 232	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**DISCOUNTS**		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 6,965,628	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,102,460	31
32	Health Care	2,092,476	32
33	General Administration	1,774,738	33
	B. Capital Expense		
34	Ownership	666,538	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	115,290	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,751,502	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,214,126	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 1,214,126	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliatio TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,294	$ 72,783	$ 31.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40,900	44,242	706,987	15.98	3
4	Licensed Practical Nurses	5,446	6,440	122,174	18.97	4
5	Nurse Aides & Orderlies	76,255	82,483	798,437	9.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,215	6,875	76,109	11.07	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,565	11,032	99,174	8.99	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,532	26,680	251,061	9.41	15
16	Dishwashers					16
17	Maintenance Workers	8,682	9,080	105,871	11.66	17
18	Housekeepers	22,295	23,617	202,165	8.56	18
19	Laundry	10,008	10,746	85,649	7.97	19
20	Administrator	2,080	2,104	86,541	41.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,785	7,107	60,977	8.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify Quality Assuran	2,080	2,126	26,430	12.43	33
34	TOTAL (lines 1 - 33)	217,923	234,826	$ 2,694,358 *	$ 11.47	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,800	1-3	35
36	Medical Director	O	4,400	9-3	36
37	Medical Records Consultant	N	4,170	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,552	10-3	39
40	Physical Therapy Consultant	L	1,488	10a-3	40
41	Occupational Therapy Consulta	Y	3,938	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	4,025	11-3	44
45	Social Service Consultant	E	4,538	12-3	45
46	Other(specify)	E			46
47	PSYCHIATRIC	S	5,625	10-3	47
48	DENTAL		3,300	10-3	48
49	TOTAL (lines 35 - 48)		$ 45,836		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

0

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRYAN LIVINGS	ADMIN	0.00%	$ 86,541
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,541

B. Administrative - Other

Description	Amount
EMI - MANAGEMENT FEE	$ 680,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 680,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,081
MIDAMERICA PROGRAM	DATA PROCESSING	1,345
INTEGRATED INVENTORY	DATA PROCESSING	1,500
NURSING CARE SYSTEM	DATA PROCESSING	9,021
KRUPNICK BOKOR	ACCOUNTING	11,100
PERSONNEL PLANNERS	U.C. CONSULTANT	475
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 27,522

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,196
Unemployment Compensation Insurance	19,280
FICA Taxes	205,509
Employee Health Insurance	121,099
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	27,878
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 440,962

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	17,303
Health Care Worker Background Chec	1,785
(Indicate # of checks perform 149)	
ADV & PROMO/MARKETING	4,987
DUES & SUBSCRIPTIONS	6,290
LICENSES & PERMITS	265
TRUST FEES, CONTRIBUTIONS,etc.	692
MGMT CO ALLOCATION	396
LESS TRUST FEES, CONTRIB, etc.	(692)
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	(4,987)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,439

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

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